MLN Connects®
Provider eNews

Medicare Learning Network®
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Thursday, March 26, 2015

MLN Connects® National Provider Calls

Medicare Shared Savings Program ACO: Preparing to Apply for 2016 — Register Now

Tuesday, April 7; 1:30-3pm ET

To Register: Visit MLN Connects® Upcoming Calls. Space may be limited, register early.

During this MLN Connects National Provider Call, CMS subject matter experts provide information on what you can do to prepare for the Medicare Shared Savings Program (Shared Savings Program) application process for the January 1, 2016, start date. This MLN Connects Call includes information on Accountable Care

Organizations (ACOs), ACO organizational structure and governance, application key dates, the Notice of Intent to Apply (NOI) submission, and the first steps in submitting an application. A question and answer session will follow the presentation.

The Shared Savings Program Application web page has important information, dates, and materials about the application process. Call participants are encouraged to review the application and materials prior to the call.

Agenda:

- Introduction to the Shared Savings Program
- What is an ACO?
- Organizational structure and governance
- Antitrust and ACOs
- Application process for January 2016 starters

Target Audience: Potential 2016 Shared Savings Program applicants.

Continuing education credit may be awarded for participation in certain MLN Connects Calls. Visit the Continuing Education Credit Information web page to learn more.

Open Payments (Sunshine Act) 2015: Prepare to Review Reported Data — Registration Now Open
Wednesday, April 15; 2-3:30pm ET

To Register: Visit MLN Connects® Upcoming Calls. Space may be limited, register early.

During this MLN Connects National Provider Call, CMS will provide a brief overview of the Open Payments national transparency program and highlight the parts of the program timeline when it is most critical for physicians and teaching hospitals to be aware and get involved. The call aligns with the beginning of the program phase when physicians and teaching hospitals are able to enter the Open Payments system and review the accuracy of data submitted about them, prior to the publication of this data on the CMS website.

The Open Payments website has important information about the program, including educational materials. CMS encourages all physicians and teaching hospitals, plus physician office staff members to visit this resource and become familiar with the Open Payments program.

Target Audience: Physicians, teaching hospitals, and physician office staff.

This MLN Connects Call is being evaluated by CMS for CME and CEU continuing education credit (CE). Refer to the call detail page for more information.

How to Register for the PQRS Group Practice Reporting Option in 2015 — Registration Now Open
Thursday, April 16; 1:30-3pm ET

To Register: Visit MLN Connects® Upcoming Calls. Space may be limited, register early.

This MLN Connects National Provider Call provides a walkthrough of the Physician Value (PV) - Physician Quality Reporting System (PQRS) Registration System, an application that serves the Value Modifier (VM) and PQRS programs. Groups can register via the PV-PQRS Registration System from April 1 through June 30, 2015, using an Individuals Authorized Access to the CMS Computer Services (IACS) user ID and password. A question and answer session will follow the presentation.

Agenda:

- Learn how to obtain an IACS account
- Learn how to use the secure, web-based PV-PQRS Registration System to register for your 2015 PQRS Group Practice Reporting Option (GPRO) reporting mechanism
- Learn the 2015 reporting criteria for PQRS group practices reporting via GPRO
- Learn how the VM will affect Medicare payments for physician solo practitioners and physicians in groups of 2 or more Eligible Professionals (EPs) in 2017, based on participation in the PQRS
- Physicians in groups of 2 or more will learn how to use the PV-PQRS Registration System to earn incentives and avoid an automatic downward payment adjustment under the VM in 2017 for not reporting PQRS
- Groups of 2 or more participating in PQRS GPRO, if applicable, will learn how to supplement the groups' reporting mechanism with the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) survey in 2015
- Groups of 2 or more EPs participating in the PQRS GPRO will learn how to avoid the 2017 payment adjustment under PQRS

Target Audience: Physicians, non-physician Medicare EPs, medical group practices, practice managers, and medical and specialty societies.

This MLN Connects Call is being evaluated by CMS for CME and CEU continuing education credit (CE). Refer to the call detail page for more information.

Medicare Shared Savings Program ACO: Application Process — Register Now

Tuesday, April 21; 1:30-3pm ET

To Register: Visit MLN Connects® Upcoming Calls. Space may be limited, register early.

During this MLN Connects National Provider Call, CMS subject matter experts cover helpful tips to complete a successful application for the Medicare Shared Savings Program (Shared Savings Program), including information on how to submit an acceptable Accountable Care Organization (ACO) participant list, sample ACO participant agreement, executed ACO participant agreements, and governing body template. A question and answer session will follow the presentation.

The Shared Savings Program Application web page has important information, dates, and materials about the application process. Call participants are encouraged to review the application and materials prior to the call.

Agenda:

- ACO participant agreements
- ACO participant list
- Beneficiary assignment

Target Audience: Potential 2016 Shared Savings Program applicants.

Continuing education credit may be awarded for participation in certain MLN Connects Calls. Visit the Continuing Education Credit Information web page to learn more.

New MLN Connects® National Provider Call Audio Recording and Transcript

The audio recording and transcript are now available for the March 10 call —*National Partnership to Improve Dementia Care in Nursing Homes and Quality Assurance and Performance Improvement (QAPI).* More information is available on the call detail web page. During this call, CMS subject matter experts provided National Partnership updates and an overview of QAPI, as well as a presentation on Adverse Events in nursing homes.

CMS Events

Volunteer for ICD-10 End-to-End Testing in July — Forms Due April 17

During the week of July 20 through 24, 2015, a third sample group of providers will have the opportunity to participate in ICD-10 end-to-end testing with Medicare Administrative Contractors (MACs) and the Common Electronic Data Interchange (CEDI) contractor. Approximately 850 volunteer submitters will be selected to participate in the July end-to-end testing. This nationwide sample will yield meaningful results, since CMS intends to select volunteers representing a broad cross-section of provider, claim, and submitter types, including claims clearinghouses that submit claims for large numbers of providers. *Note:* Testers who are participating in the January and April end-to-end testing weeks are able to test again in July without re-applying.

To volunteer as a testing submitter:

- Volunteer forms are available on your MAC website
- Completed volunteer forms are due April 17
- CMS will review applications and select the group of testing submitters
- By May 8, the MACs and CEDI will notify the volunteers selected to test and provide them with the information needed for the testing

If selected, testers must be able to:

- Submit future-dated claims.
- Provide valid National Provider Identifiers (NPIs), Provider Transaction Access Numbers (PTANs), and beneficiary Health Insurance Claim Numbers (HICNs) that will be used for test claims. This information will be needed by your MAC by May 29 for set-up purposes; testers will be dropped if information is not provided by the deadline.

Any issues identified during testing will be addressed prior to ICD-10 implementation. Educational materials will be developed for providers and submitters based on the testing results.

For more information:

- MLN Matters® Article #MM8867, "ICD-10 Limited End-to-End Testing with Submitters for 2015
- MLN Matters Special Edition Article #SE1435, "FAQs – ICD-10 End-to-End Testing"
- MLN Matters Special Edition Article #SE1409, "Medicare FFS ICD-10 Testing Approach"

Medicare Basics for New Providers Webinar — Register Now

Tuesday, March 31; 2-4pm ET

New to the Medicare Program or interested in becoming a Medicare Provider or Supplier? Need a refresher on the basics of Medicare? Register now for our upcoming "Medicare Basics for New Providers" webinar. This multi-media webinar will review the history and parts of the Medicare Program (A, B, C, and D). You will also get an overview of the process for becoming a Medicare provider, including enrollment requirements and systems.

Registration:

- To register
- This webinar will offer both continuing education units (CEU) and continuing medical education (CME) credit.

Announcements

DOJ and HHS Announce over $27.8 Billion in Returns from Joint Efforts to Combat Health Care Fraud
Administration recovers $7.70 for every dollar spent to fight health care-related fraud and abuse; third-highest on record

More than $27.8 billion has been returned to the Medicare Trust Fund over the life of the Health Care Fraud and Abuse Control (HCFAC) Program, Attorney General Eric Holder and HHS Secretary Sylvia M. Burwell announced on March 19. The government's health care fraud prevention and enforcement efforts recovered $3.3 billion in taxpayer dollars in FY 2014 from individuals and companies that attempted to defraud federal health programs, including programs serving seniors, persons with disabilities, or those with low incomes. For every dollar spent on health care-related fraud and abuse investigations in the last three years, the administration recovered $7.70. This is about $2 higher than the average return on investment in the HCFAC program since it was created in 1997. It is also the third-highest return on investment in the life of the program.

The recoveries reflect a two-pronged strategy to combat fraud and abuse. Under new authorities granted by the Affordable Care Act, the administration continues to implement programs that move away from "pay and chase" efforts targeting fraudsters to preventing health care fraud and abuse in the first place. In addition, the Health Care Fraud Prevention and Enforcement Action Team (HEAT), run jointly by the HHS Office of the Inspector General and Department of Justice (DOJ) is changing how the federal government fights certain types of health care fraud. These cases are being investigated through real-time data analysis in lieu of a prolonged subpoena and account analyses, resulting in significantly shorter periods of time between fraud identification, arrest, and prosecution.

CMS is adopting a number of preventive measures to combat fraud and abuse. Provider enrollment is the gateway to billing the Medicare program, and CMS has put critical safeguards in place to make sure that only legitimate providers are enrolling in the program. The Affordable Care Act required a CMS revalidation of all existing 1.5 million Medicare suppliers and providers under new screening requirements. CMS will have requested all revalidations by March 2015. As a result of this and other proactive initiatives, CMS has deactivated 470,000 enrollments and revoked nearly 28,000 enrollments to prevent certain providers from re-enrolling and billing the Medicare program.

CMS also continued the fiscal 2014 temporary moratoria on the enrollment of new home health or ambulance service providers in six fraud hot spots. This extension will allow CMS to continue its actions to suspend payments or remove providers from the program before allowing new providers into potentially over-supplied markets.

Similar to the technology used by credit card companies, CMS is using its Fraud Prevention System to apply advanced analytics to all Medicare Fee-For-Service claims on a streaming, national basis. The Fraud Prevention System identifies aberrant and suspicious billing patterns, which in turn trigger actions that can be implemented swiftly to prevent payment of fraudulent claims. In the second year, the system saved $210.7 million, almost double the amount identified during the first year of the program.

For more information:

- HCFAC Annual Report

- Fact Sheet

Full text of this excerpted HHS press release (March 19).

HHS Announces Proposed Rules to Support the Path to Nationwide Interoperability

Electronic Health Record Incentive Programs and 2015 Edition Health IT Certification Criteria rules proposed

On March 20, HHS, CMS, and the Office of the National Coordinator for Health Information Technology (ONC) announced the release of the Stage 3 notice of proposed rulemaking for the Medicare and Medicaid Electronic Health Records (EHRs) Incentive Programs and 2015 Edition Health IT Certification Criteria to improve the way electronic health information is shared and ultimately improve the way care is delivered and experienced. Together, these proposed rules will give providers additional flexibility, make the program simpler, drive interoperability among electronic health records, and increase the focus on patient outcomes to improve care.

The Meaningful Use Stage 3 proposed rule issued by CMS specifies new criteria that eligible professionals, eligible hospitals, and Critical Access Hospitals (CAHs) must meet to qualify for Medicaid EHR incentive payments. The rule also proposes criteria that providers must meet to avoid Medicare payment adjustments based on program performance beginning in payment year 2018. The rule gives more flexibility and simplifies requirements for providers by focusing on advanced use of electronic health records and eliminating requirements that are no longer relevant.

The 2015 Edition Health IT Certification Criteria proposed rule aligns with the path toward interoperability – the secure, efficient, and effective sharing and use of health information. The proposed rule builds on past editions of adopted health IT certification criteria, and includes new and updated IT functionality and provisions that support the EHR Incentive Programs care improvement, cost reduction, and patient safety across the health system.

For more information:

- Stage 3 Proposed Rule: Comment period ends on May 29, 2015
- 2015 Edition Proposed Rule: Comment period ends on May 29, 2015
- Draft 2015 Edition Certification Test Procedures: Comment period ends on June 30, 2015
- Blog: CMS intends to modify requirements for Meaningful Use
- EHR Incentive Program website
- Health IT Regulations website

Full text of this excerpted HHS press release (March 20).

Star Ratings for Home Health Compare: Provider Preview Reports Available in Late March

As announced in December 2014, CMS is planning to add a “star” rating to Home Health Compare (HHC) that will be a summary of some of the current measures of home health care provider performance. CMS shared plans for implementation of the HHC Star Ratings at Special Open Door Forums in December 2014 and February 2015. Visit the Home Health Star Ratings web page for:

- Links to the recordings and transcripts from the Special Open Door Forums
- Frequently Asked Questions
- Finalized HHC Star Ratings Methodology for the initial publication of the HHC Star Ratings in July 2015
- Sample report illustrating the provider preview report format

Provider Preview Reports
Providers will have the opportunity to preview their HHC Star Ratings and the calculations they are based on before they are published each quarter. They will also be able to request review of the rating by CMS if they submit evidence that the data used to calculate the measures were inaccurate or incomplete. The first round of Star Rating Provider Preview Reports will be distributed to providers (via their CASPER folders on the QIES system) in late March 2015.

CMS anticipates that the methodology for calculating the HHC Star Ratings will continue to evolve over time and welcomes additional stakeholder comments and suggestions, which may be sent to HHC_Star_Ratings_Helpdesk@cms.hhs.gov.

Medicare EHR Incentive Program Hospitals: Apply for Hardship Exception by April 1

Payment adjustments for eligible hospitals that did not successfully participate in the Medicare Electronic Health Record (EHR) Incentive Program in 2014 will begin on October 1, 2015. Medicare eligible hospitals can avoid the 2016 payment adjustment by taking action no later than 11:59 pm ET on April 1, 2015, and applying for a 2016 hardship exception. The hardship exception application and instructions for Medicare eligible hospitals outline the specific types of circumstances that CMS considers to be barriers to achieving meaningful use, and how to apply. To file a hardship exception, Medicare eligible hospitals must:

- Show proof of a circumstance beyond the hospital's control.
- Explicitly outline how the circumstance significantly impaired the hospital's ability to meet meaningful use.
- Supporting documentation must also be provided. CMS will review applications to determine whether or not a hardship exception should be granted.

If approved, the exception is valid for one year. If the hospital claims a hardship exception for the following payment year, a new application must be submitted.

Want more information about the EHR Incentive Programs? Be sure to visit the Medicare and Medicaid EHR Incentive Programs website for the latest news and updates on the EHR Incentive Programs.

Claims, Pricers, and Codes

New RARC Alerts Providers about Upcoming Transition to ICD-10

By mid-April, providers will begin seeing a new Remittance Advice Remark Code (RARC) N742 on their Remittance Advices (RAs), "Alert: This claim was processed based on one or more ICD-9 codes. The transition to ICD-10 is required by October 1, 2015, for health care providers, health plans, and clearinghouses. More information can be found at http://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html." Medicare Administrative Contractors will start-using the new RARC in April. Since RARCs are an industry standard, the new RARC has been available for other health plans to use since March 1, 2015.

This is another example of the unprecedented level of outreach by CMS to prepare the health care community for ICD-10. CMS has a very mature and rigorous testing program for its Medicare Fee-For-Service claims processing systems and has completed extensive testing in preparation for ICD-10. CMS is ready for ICD-10 and encourages medical practices and hospitals that bill Medicare to complete their preparations for the October 1, 2015, implementation date.

Updates to IRIS Software

The IRIS software programs (IRISV3 and IRISEDV3) each have three updated files (medical school codes, residency type codes, and IRISV3 Operating Instructions) for collecting and reporting information on resident training in hospital and non-hospital settings. They are categorized as follows: August 2014 IRISV3 Operating Instructions and Excerpts from IRISV3 Operating Instructions to Use with IRISEDV3:

- CMS added nine new IRIS residency type codes to the IRIS Residency Type Code Table.
- CMS also added seven new IRIS medical school codes to the IRIS Medical School Code Table.
- Providers may begin using the new medical school and residency type codes in the IRIS programs for cost reporting periods ending on or after June 30, 2014.

The IRIS programs are available for downloading via the IRIS website.

FY 2015 Inpatient PPS PC Pricer Update Available

The FY 2015.3 Inpatient Prospective Payment System (PPS) PC Pricer has been updated with a logic correction and is now available with January 2015 provider data on the Inpatient PPS PC Pricer web page in the "Downloads" section.

Medicare Learning Network® Educational Products

"Safeguard Your Identity and Privacy Using PECOS" Fact Sheet — Reminder

"Safeguard Your Identity and Privacy Using PECOS" Fact Sheet (ICN 909017) is available in a downloadable format. This fact sheet is designed to provide education on how to ensure Medicare enrollment records are up-to-date and secure. It includes step-by-step instructions on how providers can protect their identity while using Internet-based Provider Enrollment, Chain & Ownership System (PECOS).

"Internet-based PECOS FAQs" Fact Sheet — Reminder

"Internet-based PECOS FAQs" Fact Sheet (ICN 909015) is available in a downloadable format. This fact sheet is designed to provide education on Internet-based Provider Enrollment, Chain & Ownership System (PECOS). It includes information on many frequently asked questions related to enrollment applications, application fees, revalidations, and much more.

Medicare Learning Network® Product Available In Electronic Publication Format

The following product is now available as an electronic publication (EPUB) and through a QR code. Instructions for downloading EPUBs and how to scan a QR code are available at "How To Download a Medicare Learning Network® Electronic Publication."

"Medicare Physician Fee Schedule" Fact Sheet (ICN 006814) is designed to provide education on the Medicare Physician Fee Schedule (PFS). It includes the following information: physician services, Medicare PFS payment rates, and resources.

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